Home Care for Sick Persons organised by Hospitals

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For a variety of reasons, which will be discussed later, a number of hospitals in the United States have organised programmes whereby patients suffering from chronic disorders are looked after in their own homes. The pioneer hospital and the one which has the most carefully studied programme is Montefiore Hospital in the Bronx, New York. It is proposed briefly to discuss the programme of that hospital and to endeavour to see what features of the "Home Care" activities organised by that hospital would be of value in Northern Ireland.

It should be made clear first that both in Montefiore and in other hospitals which operate such programmes, the original intention was simply to save hospital beds by moving patients to their homes and organising attention for them there when it had become clear that they were going to be sick for very long periods, perhaps for the rest of their lives.

That this aim has been achieved is clear, as will later be shown, but all those concerned with established schemes have in time become convinced by their experience that even if money were not saved, the programmes would be amply justified. This is because of the happiness and contentment of patients in their homes and of the remarkable efforts of their families to help them. The humanising and "individualising" of attention so difficult to attain in hospital are common happy results of home care. In addition, it appears that people in their own homes frequently make surprising recoveries, or, at least, retain function longer than would be expected in hospital.

The "man in the street" probably gives very little consideration to the purposes of hospitals, but regards them as places where very sick people are admitted. In practice, the factors which determine whether or not a sick person shall be admitted to hospital are numerous, complex, and interrelated, and it is by no means easy to estimate the importance of single factors in any given area.

It is difficult to find convincing figures indicating whether the overall average duration of stay in hospital is increasing or decreasing, but it is certain that the cost of hospitals, measured on the usual basis per bed per day, is increasing at an alarming rate. It is, therefore, important to note the factors which will influence the admission of patients to hospital, even if the relative importance of these factors cannot be assessed.

The new therapies, such as sulphonamides and anti-biotics, which help to control infectious conditions have modified the types of cases admitted and have diminished materially the mean duration of many infective conditions. However, over the period in which these therapies have been introduced, there have been parallel developments in the methods and techniques of investigations, and new methods of treatment of the variety of "replacement therapy" have been elaborated. These

latter procedures usually call for admission for investigation and adjustment to treatment of many persons who would previously have been investigated briefly and then discharged to "observation," so that the new diagnostic procedures have increased the pressure on beds.

The right of access to hospitals instituted by the National Health Service and the extreme pressure of work on family doctors have, no doubt, contributed also to increases in the numbers of persons seeking admission to hospital.

There are, in addition, a number of purely social factors which have influenced the demand on hospital beds. As the years pass, people are more willing to go to hospital, because hospitals are less feared and the thought of treatment more easily accepted. In many instances people seek admission to hospital or are advised to go there by their doctors, not so much because admission is necessary for diagnosis or treatment, as because of home circumstances and the difficulty of procuring nursing and domestic attention. It is probably not unimportant that hospital care is free, while help necessary to keep a patient at home is costly at the present time. It would seem, however, that poverty should not be a reason either for or against admission to hospital.

Finally, the distribution and type of illness in the population has been greatly altered by the reduction of wastage in the first two decades of life and by an increase in the absolute number of old people, so that there is an increasing relative and absolute amount of degenerative disease which is chronic and slowly progressive.

The factors of staff difficulties and the trend in favour of reducing bed congestion in old, overcrowded hospitals inevitably aggravate the problem and the numerous difficulties attending new construction do not offer much hope that new beds or hospitals provided in the next decade will relieve the problem entirely.

In essence, then, the problem facing hospital administrators at the present time is that diagnosis, treatment, and nursing care in hospital are extremely expensive. If equally good care can be given out of hospital or with fewer days in hospital, and if that attention can be given at less cost, then it would seem worthwhile making an attempt to provide a new kind of home care service.

Such a home care programme must not be envisaged merely as the making of arrangements whereby the existing duties of health and welfare authorities to provide nursing and domestic assistance are implemented fully. Nor must it be thought suitable only for the aged and infirm, and, therefore, it should be independent of (although collaborating freely with) a geriatric unit. Rather its function should be to provide, where social circumstances make it possible, for patients, who, unless this special service were available, would have to be treated in hospital because of the nature or severity of their illness.

The Montefiore Home Care Programme

In the Montefiore Hospital there is a Home Care Section under the direct administration of Dr. Martin Cherkasky, the Deputy Medical Superintendent of the Hospital. The staff consists of full- or part-time physicians, the equivalent of

the services of two full-time physicians being required. In addition, the entire staff of the hospital is available for consultations. At present some 160 patients are being looked after by Home Care who would otherwise be in hospital. There is one full-time and one part-time social worker and the part-time services of one supervisor of social work. There is one full-time occupational therapist and the part-time services of physiotherapists are available also. Nursing is provided by the Visiting Nurse Service of New York. Housekeeping services are obtained from the New York State Employment Bureau and from various voluntary agencies.

Patients accepted by the Home Care Section are still regarded technically as "on the books" of the hospital and their records are kept in exactly the same way as if they were in-patients. Most of the patients are transferred to the Home Care Section from a ward of the hospital, but some are referred from the out-patient department and some are accepted when referred by other hospitals in New York.

The procedure in the hospital is that the physician or surgeon in charge, having decided that the continuation of treatment or supervision in hospital is no longer advisable or necessary, notifies the Home Care Section of his opinion, using the proforma reproduced in the appendix to this note. On receipt in the Home Care Section, the patient is seen by a physician from that Section and, if he decides that the medical condition of the patient makes it reasonable to attempt home care, then he agrees to accept the patient, subject to agreement by the social service. The social worker sees the patient, the relatives, and, if necessary, the home, and decides whether there is a good chance of meeting the medical and social needs of the patient in his or her own home.

The grounds of acceptance by the medical service will clearly depend on whether the procedures necessary for comfort, diagnosis, and treatment can be carried out in the home, or at least with an occasional visit to hospital. At times a trial is considered well justified. The social worker's decision rests in the first place on whether the patient can afford proper medical attention in his own home. If he can, then he is not accepted, but referred to his own doctor. For the rest, the accommodation, sanitary condition, and equipment in the home are assessed. The decision finally rests on the relatives or friends in the home who are prepared to face the tasks of giving the patient such assistance as is required. It may be emphasized again that it will obviously be impossible for the physician or social worker always to be true prophets, and a trial will often be worthwhile.

After the patient goes home, a visit is paid by the physician and by the social worker as soon as possible. Arrangements are made for nursing and domestic assistance, as required. It may be noted that it is frequently found that relatives prefer (before or after experience) to assume nursing and domestic responsibilities, which in the preliminary stages have been adjudged too great by them or by the social worker.

The occupational therapist always visits the patient, and specialist consultations by the hospital staff are arranged as required. Apparatus and equipment are loaned from the Home Care Section or nursing organisations, and remedies are prescribed exactly as for a patient in hospital. Thereafter the patient is visited as often as is

necessary by the doctor and the other members of the team, and a wide variety of treatment and minor diagnostic procedures are carried out in the home. For example, dressings, replacement of self-retaining catheters, paracentesis, taking of specimens of blood, and blood transfusions are commonly performed by the doctor on his visits.

If a more complex investigation is required, the patient may be taken by ambulance to hospital for the purpose and either returned the same day or accommodated for a few days and then taken home. Examples of procedures necessitating such journeys to hospital are X-ray examinations, radiotherapy, minor operations, or metabolic studies. When a patient has improved, he may be discharged completely or he may be discharged to attend as an out-patient. If his condition indicates, he may be re-admitted to hospital and this is frequently done in cases of neoplasm before the patient's death.

The following quotations from the Second Annual Report of the Department of Home Care, Montefiore Hospital, may serve as a starting point for estimates of the cost of such a scheme in Northern Ireland :—

EXPENDITURES ITEMIZED

Medical Services	$16,940.33
Home Care Executive	2,749.95
Clerical Services	3,189.85
Social Service	4,268.96
Occupational Therapy	1,417.91
Hospital and other equipment	2,414.26
Medications	4,283.19
Laboratory	311.47
Transportation	1,901.41
Visiting Nurse Service	3,995.27
Housekeeping Aid	3,286.90
Physical Therapy	3,152.02
Administrative Expenses and Supplies	1,776.08
Total	49,687.60
Total Funds for 1948	68,274.86
Expenditures	49,687.60
Balance remaining as of January 1, 1949	$18,587.26

"$49,687.60 represents the cost to the Department of Home Care for services to 197 patients during the year (several of the patients were on home care more than one time, but are here counted as only one patient). The total days of services rendered was 19,842. The average cost to the Department of Home Care was $2.50. The cost has risen since last year, due primarily to (1) expanded service, and (2) to the increased cost of personnel.

"Two dollars and fifty cents was the actual amount expended per patient day. However, there are certain other costs which should be included if we take into account contributions made to the programme. First of all, the Visiting Nurse Service, in providing care for patients who were receiving welfare subsidies from the City of New York received part of the cost of the call ($1.75 as opposed to $2.25 for a full call) from the City. In addition, some of the patients had insurance policies which entitled them to a certain amount of nursing. These two items would total $890.85, which should be added to the cost of nursing service. The City of New York also provided medications for those patients who were on the Welfare Panel. We estimate this would have cost the Department of Home Care an additional $900. One other item which we were not required to pay for, due to the generosity of Montefiore Hospital, was overhead, which would be a factor in any Home Care programme which might be contemplated. We figure this at eight per cent. The United Order of True Sisters supplied us with some of the equipment used in the home, such as bed trays, bedpans, etc., and with some of the dressings. (Including all these items, a corrected figure of $2.82 per patient day is the net cost.) *The present cost of hospital care is more than $13 per day,* so that it can be safely said that Home Care is less than a quarter of the cost of hospital care. It must also be recognised that in Home Care costs, physicians' fees are included and this represents about a third of our budget. These fees are not ordinarily considered in the cost per patient day for voluntary hospitals, since most physicians' services are rendered free of charge in such institutions. The question arises whether the cost per patient day on Home Care should be compared to the cost per patient day in the hospital.

"We estimate that about 85 per cent. of the patients who are on the Home Care programme at this time would have to occupy a hospital bed were it not for our ability to care for them at home.

"We have increased Montefiore Hospital's capacity without costly construction, and at a cost per day which is about one-quarter of hospital cost. We have found that suitable patients can be taken care of at home with great benefit to them. We have accumulated a great deal of information on the social aspects of long-term illness."

An excerpt from the editorial on Home Care appearing in the American Journal of Public Health, February, 1949, might be very pertinent here in view of the expanding interest in Home Care.

> "This programme makes a contribution of major importance to the technology and to the philosophy of medical care. It is essential, however, to remember that its successful application depends on a high degree of hospital development, in the fields of medical staff, social service, nursing, physical and occupational therapy. It would be most unfortunate if so fruitful a concept were to be discredited by wholesale displacement of patients by hospitals which lack the facilities to carry the programme out successfully.
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> "There are many human interest stories which can be told about patients, who, having come on Home Care and been seen in their family settings, have been helped almost miraculously by the combined skill of our doctors, our

social workers, and our public health nurses, along with the ancillary services. The doctors on the programme have developed an insight into the rôle that social factors play in disease, and, in view of the increasing importance of long-term illness in our society, such understanding is of great importance."

Applications in Northern Ireland

There are one or two local circumstances in the United States which differ quite radically from those pertaining here and which render even a trial of Home Care on precisely the same pattern impossible. The fundamental difference is that every person here has a family doctor and has no financial worry about doctor's fees. The family doctor has already had too many of his responsibilities removed and he must come into any scheme which proposes to offer hospital facilities to any of his patients in their own homes.

The vast majority of general practitioners are already fully occupied and it is unreasonable to expect them gratuitously to offer their services for the heavy and trying work of looking after chronic invalids in their own homes, if by expressing an opinion they can be cared for in hospital. The rigidity of the per capitum system of payment in this, as in many other ways, reacts very unfavourably on the initiative and will to constructive work of general practitioners. However, it seems reasonable to expect that in every area there will be found a number of practitioners who would be willing to take an active part in a hospital Home Care scheme, but it would be quite unreasonable to expect them to do so unless they were paid for the onerous extra duties to which they would commit themselves.

It would appear that, properly used, such a Home Care scheme could be utilised as an instrument of "rehabilitation" of the practitioner, rather than as a further curtailment of his responsibilities and prestige in the community. It might well be one way of giving the practitioner a useful hospital connection, and it would seem that if hospitals were saving beds and expense by arranging for medical attention of a hospital standard in the patient's home, they would be amply justified in paying the practitioner who gave much of the medical attention to the patient.

Then there are the two committees and their servants of the local authorities who have statutory duties in this field of Home Care—the Health Committees and the Welfare Committees. Any scheme would be ill-starred which failed to take into account the duties of these bodies and the organised nursing and domestic services which they can provide. There are other public authorities whose co-operation would also be essential: Education Committees, the Assistance Board, and the Ministry of Labour are examples. There are also interested voluntary bodies.

Nevertheless, such a scheme stems from the hospital; its justification lies in the possibility of providing as good or better medical care than the patient would get in hospital, and therefore the control should lie ultimately in a Home Care section of a hospital. The principle of having patients under Home Care "on the books" of the hospital and regarded as patients receiving active treatment from the hospital seems most valuable and should be retained.

A Suggestion for Discussion for a Trial Home Care Scheme

Clearly, supposing that a trial is deemed advisable, there would be many difficulties to be overcome in getting it under way. There are many considerations which would influence the organisation of such a trial. Nevertheless, I venture to make suggestions in the hope that this outline serves only as a starting point for discussions which would carry the possibility of a trial much further and which would finally launch a trial on sound lines.

A Hospital for a Trial Run

Supposing the trial could be begun in one hospital, then the following considerations affecting the hospital chosen would be important. The hospital would require to be large, so that the number of suitable cases would justify the trial. For similar reasons, the hospital would have to provide a considerable number of cases of chronic or long-term illness. The consultant staff of the hospital would have to agree to act as consultants in the scheme and to co-operate by putting forward suitable cases and by accepting the final decision of the Home Care section. Finally, in the area served by the hospital there would have to be a group of practitioners who would be willing to participate in a trial.

A Home Care Section

In the chosen hospital it would be necessary to set up a Home Care Section, headed by a physician on the staff of the hospital. There would also have to be one full-time qualified almoner and probably a nurse (preferably with Health Visitor's qualifications). The part-time services of an occupational therapist would also be required.

It is suggested that the rest of the medical staffing should in the first instance be by a group of general practitioners known to send a considerable number of their patients to the hospital. They would act in respect of their own patients only. Finally, transport for the staff is an absolute essential and the scheme would fail if this were not provided.

Patients would be accepted for Home Care on agreement of the permanent staff in the first instance, always with the approval also of the general practitioner of the patient. In time, it would, no doubt, be possible to find general practitioners who were willing and able to see their own patients in the wards, when they had been proposed for Home Care, and to make the medical decisions as to acceptance.

It does seem very important, however, that the decision as to suitability should primarily be determined by whether the patient's medical needs can be met in the social circumstances existing in his home and, therefore, the decision as to a trial of Home Care should rest ultimately with the Home Care Section of the hospital, in consultation with the patient's family doctor.

Reference

Montefiore Hospital, New York City: "Home Care"; 1947.

APPENDIX A

SECTION 42 of the Health Services Act (N.I.), 1948, provides that Health Authorities may, with the approval of the Ministry, and to such an extent as the Ministry may direct, shall make arrangements for the purpose of the prevention of illness, *the care of persons suffering from illness or the after-care of such persons* . . . ''

Similarly, under Section 43, they may make arrangements "for providing domestic help for households where such help is required owing to the presence of any person who is ill . . . ''

It would seem, then, that there should be no insuperable obstacles to the fruitful co-operation between the Hospitals Authority and the Health Authorities, because the context of these sections makes it clear that the function of the Health Authorities is essentially to provide good nursing and social services, so that there would be no marked overlapping between hospitals and Health Authorities.

APPENDIX B

MONTEFIORE HOSPITAL—HOME CARE REFERRAL

Name Age Ward or Agency Date

Address Apt Floor Telephone No.

Nearest Relative Address

Is patient on Dept. of Welfare Yes No. If so, Welfare Centre No.

Diagnosis (complete details) :

The Patient is : Ambulatory ( ); Wheelchair (partial-complete) ( ); Bedridden (partial-complete) ( ).

Patient's ability to care for self at home :

Medication :

Physician's Signature.

Report by hospital nurse (observations, results of teaching, etc.) :

Nurse's Signature.

PLEASE NOTE

1. This form should be filled out completely and sent to the Department of Home Care when a patient no longer requires hospitalisation.
2. The completion of this form *does not mean that the patient is accepted for Home Care.*

TO BE FILLED OUT BY THE DEPARTMENT OF HOME CARE

Medical Decision : Accepted :

Rejected (state reason) :

Social Service Decision : Accepted.

Rejected (state reason) :